SPOUSE/DEPENDENT APPLICATION FOR COVERAGE

KENTUCKY ACCESS

MAIL TO:
KENTUCKY ACCESS
P.O. Box 33707
Indianapolis, Indiana 46203-0707

Phone: 317.614.2133
1.866.405.6145
www.kentuckyaccess.com

Please type or print in black ink. All questions must be filled out with complete detail (attach a separate piece of paper if necessary). If you have questions while completing the application, log onto our web site at **www.kentuckyaccess.com** or call **Customer Service** at **1.866.405.6145**.

☞ Subscriber's name and identification number for spouse / dependents to be covered. Please complete the following:

SECTION I: SUBSCRIBER'S INFORMATION

A

LAST NAME	FIRST NAME	INITIAL

PLAN NO.	BIRTH DATE (MO/DAY/YEAR)
	/ /

SECTION II: SPOUSE / DEPENDENT INFORMATION

List spouse / dependents to be covered under this plan. Dependents must be (1) unmarried and under the age of 19, (2) unmarried, under the age of 25, a full-time student at an accredited high school, trade school, college or university, and chiefly dependent upon you for support, OR (3) unmarried, incapable of self-sustaining employment by reason of mental or physical disability, and chiefly dependent upon you for support. Proof may be required.

Please note that all parties to be covered under this plan must meet the requirements set forth in Part IV.

B

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

C

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

D

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

E

LAST NAME	FIRST NAME	INITIAL	SOCIAL SECURITY NUMBER
			– –

RELATIONSHIP TO APPLICANT	FULL-TIME STUDENT	INCAPABLEOF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL OR PHYSICAL DISABILITY	SEX (check one)	BIRTHDATE: MONTH DAY YEAR	AGE
☐ Spouse ☐ Child	☐ Yes ☐ No	☐ Yes ☐ No	☐ Male ☐ Female	/ /	

SECTION III: ELIGIBILITY REQUIREMENTS

F **SUBSCRIBER MUST BE A RESIDENT OF KENTUCKY.** "Resident" refers to a person who has, for at least 12 months immediately preceding this application for insurance, resided continuously in the State of Kentucky in a place of permanent habitation.

PROOF OF RESIDENCY IS REQUIRED IF YOU ARE NOT FEDERALLY ELIGIBLE UNDER HIPAA OR ENROLLED IN A GAP PROGRAM. At least **one** of the following documents or other evidence of residency **must accompany your application**; a receipt 12 months prior to date of application **AND** another receipt within the last 3 months prior to date of application for rent, mortgage payment, utility bills, or a resident Kentucky income tax return for the most recent 12 month tax period, a copy of your Kentucky driver's license issued at least 12 months ago **OR** a copy of your Kentucky personal identification card issued by the Kentucky Department of Transportation dated 12 months or more prior to date of application for Kentucky Access.

I have been a resident of the State of Kentucky continuously since _____ (month / day / year).

_____ **Initial Here**

F-1 Spouse / dependent(s) enrolled in Medicare or Medicaid are not eligible for this plan.

F-2 Spouse / dependent(s) who are eligible for coverage under a medical insurance plan are not eligible for this plan.

F-3 Dependent children (if to be covered) can only be covered as long as one of the following requirements are met:

- Unmarried and under the age of 19, or
- Unmarried and under the age of 25 and is a full-time student in any accredited high school, trade school, college or university and is chiefly dependent on you for support, or
- Unmarried and incapable of self-sustaining employment by the reason of mental or physical disability; and is chiefly dependent on you for support.

SECTION IV: PRE-EXISTING CONDITIONS PROVISION

G Benefits under any Kentucky Access Plan (including spouse/dependent) will not be payable for a pre-existing condition (injury or sickness) for 12 months following the effective date of coverage if medical advice, diagnosis, care or treatment for the pre-existing injury or sickness was recommended or received within a period of six months before the effective date of coverage. The 12 month period may be reduced by the number of months for which you have creditable coverage. A copy of the **Certificate of Creditable Coverage** provided by your previous health insurance carrier / employer or other evidence of medical coverage **must be sent along with this application**.

WAIVER BENEFIT (automatic for federally eligible individuals**)**: You and any person named on this application may be eligible for a waiver of the pre-existing condition waiting period if you are an eligible individual. A copy of the **Certificate of Creditable Coverage** provided by your previous health insurance carrier / employer or other evidence of medical coverage **must be sent along with this application**.

PLEASE ANSWER THE FOLLOWING QUESTION:

☐ **YES** ☐ **NO** Has any spouse/dependent named on this application received medical advice, care or treatment in the six months preceding this application?

If **YES**, please provide **Medical Information** for each person (attach an additional sheet of paper if necessary).

SPOUSE/DEPENDENT NAME	PHYSICIAN NAME	DIAGNOSIS	TREATMENT and/or MEDICATION	DATES OF TREATMENT	DATES OF HOSPITALIZATION

SECTION V: OTHER COVERAGE

If any person named on this application is enrolled in Medicare or Medicaid then that person would not be eligible for coverage through Kentucky Access.

H ☐ YES ☐ NO Is any spouse / dependent named on this application enrolled in **Medicare**?

If **YES**, name of person(s): _____ _____

Identification Number(s): _____ _____

Effective Date(s): Part A _____ Part A _____

Part B _____ Part B _____

I ☐ YES ☐ NO Is any spouse / dependent named on this application enrolled in **Medicaid**?

If **YES**, name of person(s): _____ _____

Identification Number(s): _____ _____

Effective Date(s): _____ _____

J ☐ YES ☐ NO Do you or any spouse / dependent named on this application have any other **medical or hospital insurance**?

If **YES**, name of person(s): _____ _____

Insurance Company Name: _____ _____

Insurance Company Phone: _____ _____

Is it a Group Plan? ☐ YES ☐ NO Is it a Group Plan? ☐ YES ☐ NO

Is it your intent to replace it with this coverage? ☐ YES ☐ NO If **YES**, please explain reason for replacement.

Reason(s) must meet requirements stated in Part IV.

_____

_____

_____

_____

SECTION VI: DISCLOSURE AUTHORIZATION AND DECLARATION

THE FOLLOWING INFORMATION DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I authorize the release of any medical or other information, including but not limited to claims, conditions, and treatment, concerning myself or for any dependents listed herein, by any provider of health services, the Veterans Administration, pharmacy benefit managers, the Medical Information Bureau, Inc., my employer, insurance company, health maintenance organization or otherwise, to Kentucky Access, Division of the Kentucky Department of Insurance ("Kentucky Access") and its subsidiaries, affiliates, and any administrators, agents or other entity providing services on behalf of Kentucky Access.

This information will be used for treatment, payment or healthcare purposes which include but are not limited to claims, claims administration; claims adjustment and management; detection, investigation or reporting of actual or potential fraud; misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers' compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rule promulgated by the U.S. Department of Health and Human Services at 45 CFR 160, et seq.; disclosure that is required, or is one of the lawful or appropriate methods, to enforce Kentucky Access' rights or the rights of persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process.

I understand and agree that Kentucky Access may furnish this information to other entities, which may include insurers, pharmacy benefit managers and government agencies. Kentucky Access will advise such entities that such information must be kept confidential to the extent necessary or as otherwise required by law and should not be used for any unlawful purpose. This information includes any records of knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted disease or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider.

I understand that any misstatements or failure to report new medical information prior to approval of my application may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or recision or cancellation of my coverage(s).

Any person who knowingly and with intent to defraud Kentucky Access, or makes a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact regarding the material thereto, commits a fraudulent insurance act, which is a crime.

This authorization will be valid from the date signed.

I hereby acknowledge that I have received and fully understand the Application for Kentucky Access and that the information contained in the application may only be used in the administration of Kentucky Access.

I have read or had read to me, all of the above questions and my answers to them and I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge. I understand that any false statement or misrepresentation in the application may result in loss of coverage under the Kentucky Access coverage being applied for.

I understand that no coverage will be effective until the full initial premium is paid and this application has been approved. I further certify that in the event I obtain other similar health coverage or change my residency, I will notify Kentucky Access of the other coverage or of my new address.

Signature of Subscriber	Date	Signature of Spouse / Non-Minor Dependent	Date
Signature of Subscriber	Date	Signature of Spouse / Non-Minor Dependent	Date
Signature of Subscriber	Date	Signature of Spouse / Non-Minor Dependent	Date

SECTION VII: PREMIUM PAYMENT

K

PLEASE CHOOSE ONE OF THE PREMIUM PAYMENT OPTIONS BELOW:

- ☐ **MONTHLY**
- ☐ **QUARTERLY** - 3 MONTHS PREMIUM DUE WITH APPLICATION.
- ☐ **SEMI-ANNUAL** - 6 MONTHS PREMIUM DUE WITH APPLICATION.
- ☐ **ANNUAL** - 12 MONTHS PREMIUM DUE WITH APPLICATION.

If automatic bank withdrawal is your chosen method of payment and the banking information is different than that on file with the subscriber, please submit an electronic funds transfer form with the correct information.

L

Premium $_____

Note: No payment is required with spouse / dependent application. You will be billed after the application is approved.